was introduced for insulating purposes. Next some fine silver wire was introduced into the sac through the double cannula. While putting in the wire the writer tried to avoid the communication between the sac and aorta by keeping the end of the cannula to one or other side of the sac. After some wire was introduced, it was connected with the negative terminal of a constant-current battery, the current being completed through the patient by means of an electrode placed on the thorax. A current of from 15 to 25 milliampères was given and continued for fifteen minutes, when the aneurysm felt harder and the expansile pulsation had grown less, if it had not quite disappeared. The wire (about six feet) was then pushed in, the cannula withdrawn, the purse-string suture tied, and the abdomen closed. The patient suffered greatly from shock, and died five and a half hours after the operation. The postmortem showed that the aneurysmal sac communicated with the aorta by means of a narrow, elongated mouth, about one and a half inches long. The sac was filled with a dark clot and coiled wire, a double loop of which had entered the aorta and passed, for about two and a half inches, up into the thoracic aorta. The rapidly fatal termination was undoubtedly favored by the interference with the functions of the stomach, which was stretched around the left and lower border of the aneurysm. The patient failed rapidly before the operation, and became increasingly anxious that something should be tried to relieve him, even if it were not successful.

The Pathology of Prolapse of the Rectum and its Operative Treatment by a Plastic Operation on the Pelvic Floor.—HOFMANN (*Zentralblatt f. Chirurgie*, September 2, 1905) thinks that our present methods of treatment, including operations, leaves much to be desired. Recurrences have probably been more frequent than positive successes in the hands of all. Those operative measures aiming at a cicatricial contraction of the anal orifice are insecure and disappointing, except, perhaps, the method of Thiersch, by the introduction of a wire ring around the anus, that not only contracts the anal orifice, but may be compared to a well-fitting truss, which, while it does not cure, prevents dangerous complications. The striking results sometimes obtained from the Thure-Brandt massage is explained by the increased strength given to the muscles of the pelvic floor.

Hofmann believes that prolapse is not caused by a prolapse of the mucous membrane first, and then a dragging out of the rectum, but, as Waldeyer thinks, it is like a hernia, the result of intra-abdominal pressure and weakness of the retaining wall; in this case the pelvic floor. An impaired pelvic floor is necessary to its production, the anal opening furnishing what corresponds to the hernial orifice.

The uterus prolapses only when it is deprived of a supporting pelvic floor. The role played by this support explains the well-known fact that the prolapse of the rectum occurs usually in children and weak women. In children the straight sacrum, the weakness of the muscles, and the strong intra-abdominal pressure exerted by children in defecation favor prolapse. Spontaneous cure results from gradual increase of strength in this region with the development of the child. To the same explanation may be attributed the favorable results following the Thure-Brandt method of massage. The failure after colopexy is due to the continuance of the weak pelvic floor. There is even a tendency to prolapse after a high amputation of the rectum for cancer, the pelvic floor having been weakened by the operation.

The essential muscles supporting the perineum are the levator and the sphincter ani. The latter strengthens the small end of the funnel-shaped levator ani, which draws the anal canal forward. These are aided by the other small muscles, as the coccygeus, etc., and the pelvic fascia. In prolapse the anus approaches the tip of the coccyx.

Hofmann aims by his operation to restore the weakened pelvic floor to the normal. After a careful preparation of the part an H-shaped incision is made, the transverse limb passing along the junction of the skin and mucous membrane at the posterior border of the anus, and the two lateral limbs extending upward alongside the anus and downward toward the coccyx. In the anterior part the incision should be about 4 to 5 cm. deep. The two flaps thus formed, the anterior including the rectum, are separated anteriorly and posteriorly, forming a funnel-shaped cavity, which is then closed by transverse sutures placed at different depths. Finally, the edges are sutured by non-absorbable material, the line of sutures being directed anteroposteriorly. This resembles the Lawson Tait operation for a lacerated perineum. A stricture of the rectum is impossible, and there is no sacrifice of plastic material. Primary healing is necessary to a successful result. In the case of a very large prolapse of the rectum a colopexy may be done to replace the sigmoid flexure and descending colon in their normal positions, but Hofmann thinks that generally this will not be necessary.

Researches on the Lymphatics of the Human Prostate.—CAMANTI (*Annales des maladies des organes genito-urinaires*, October 1, 1905) states that the greatest difficulty in studying the lymphatics of the prostate is in the proper injection of parenchymatous organs. He refers to the technique of various investigators and emphasizes the superiority of a weak solution of silver nitrate (1½ to 1 per cent.) as an injecting fluid. The syringe was passed into all parts of the gland until it was thoroughly saturated with the solution.

Under the microscope the lymphatic vessels were seen coming from all directions, anastomosing with each other, forming irregular networks. They increased in size from the centre to the periphery, passing through the capsule, on which the trunks assumed gradually a longitudinal direction. Camanti called this arrangement the periprostatic plexus.

A network of vessels was found in the submucous tissue of the urethra, which passed to the periphery, forming larger vessels by coalescence. The arrangement of the lymphatics in the prostatic tissue varied with different sections of the organ. At the apex they were equally distributed in the tissue. In the middle part, on the contrary, they were more abundant and complex. Finally at the base of the prostate they appeared as small spaces, although the combined calibre was greater. The lymphatics are much more tortuous and dilated than the blood-vessels.

In the interior of the gland the lymphatics originate from the acini. They form a delicate network between the acini, which terminates at the origin of the excretory duct and unites with the lymphatics coming from the ducts. In this way an irregular network is formed, invading all parts of the glandular tissue and ultimately ending in trunks. These